

APPLICATION PREFACE AND GENERAL QUALIFICATIONS

Welcome to the application process, the path to becoming a resident at one of California's extraordinary Veterans Homes. We encourage all eligible veterans to apply for admission. California's Veterans Homes are operated as an expression of gratitude toward our State's veterans.

To save time, before you start to fill out the application form, check to see that you meet the basic qualifications for admission. In brief, these qualifications are:

- 1. You are age 62 or over and, or, you have a significant disability.**
- 2. You served in the military and you were honorably discharged.**
- 3. You are still able to live independently or you qualify for a higher level of care offered at one of the Homes (contact the Home for clarification on qualifying for a higher level of care).**
- 4. You are a California resident.**
- 5. You are able to live with and get along with other people in a structured communal environment.**
- 6. You must be participating in a qualified federal, state or private health service plan, a United States Department of Veterans Affairs medical program, or have an application pending for such coverage. A non-veteran applicant must be participating in a qualified federal, state, or private health service plan to be admitted to the Home.**

Further information about the Homes, instructions on filling out the application and the admission process can be found online. Go to www.cdva.ca.gov > click on [Veterans Homes](#) > click on [Download the Application Package for the Veterans Home of California](#) > click on [Information for Applying to the Veterans Home of California](#). On the website you will also find specific information about each Veterans Home.

If you need additional help completing this application or have questions, you can call any of the phone numbers found on page A-4.

TABLE OF CONTENTS AND PREFACE

The application package has seven sections. The applicant completes most sections but some are completed by friends, family, and or physicians. This is the first step in entering a State Veterans Home.

<u>Section</u>	<u>Completed By:</u>
Section A: Background Information	Applicant
Section B: Authorization for Use and/or Disclosure of Resident/ Patient Health Information	Applicant
Section C: Michigan Alcohol Screening Test – Geriatric (MAST-G)	Applicant
Section D: Drug Abuse Screening Test (DAST)	Applicant
Section E: Declarations	Applicant
Section F: Social Functioning Assessment	Friend / Family / Social Worker
Section G: Physician's Medical Certificate	Physician

PREFACE

This application should be completed to the best of your ability. It is the first step in gaining admittance to a California Veterans Home. Having a physician complete the Physician's Medical Certificate and receiving copies of your medical records are often time consuming. Contact your physician as soon as possible to set up an appointment to complete Section G.

Usually the slowest part of the application is waiting for your medical records to arrive at the Admissions Office. Section B provides you with a release form to use in requesting your records from hospitals or other health care providers. Even with Section B completed, it is recommended that you obtain copies of your medical records and send them directly to the Admissions Office to avoid delays.

If your application is approved you will be scheduled for admission to a Veterans Home only upon providing the following documents. These documents can be submitted ahead of time with your application package.

A copy of:

- DD Form 214, Certificate of Release or Discharge From Active Duty
- Proof of California Residency, See Section A, page 1, California Residency
- Completed financial disclosure form
- Copies of Medicare card and other health insurance cards if available.

BACKGROUND INFORMATION

A

Personal Information

Full name _____
Last First Middle

Social Security number _____ Date of birth _____

Driver license number _____ State _____

Home address _____
Street City State Zip Code

Mailing address (if different from above) _____

Home phone _____ Other phone _____

Place of birth _____ U.S. citizen? ☐ Yes ☐ No

If not a U.S. citizen, resident alien number: _____

Are you: _____ Male _____ Female

Marital Status

Are you currently married? ☐ Yes ☐ No

If yes, please answer the following questions:

How long have you been married to your current spouse? _____

Is your spouse a veteran? ☐ Yes ☐ No

Is your spouse also applying for admission to VHC? ☐ Yes ☐ No

Spouse's full name _____
Last First Middle

California Residency

Initial here _____ I am a bona fide resident of the State of California. **I am submitting a copy** of the following proof of my residency (please check one or more).

- Valid California Drivers License
- California Department of Motor Vehicle Identification Card
- Registered Voter Status
- Utility Bill that shows the applicant's residence
- Paying California State Income Taxes as a resident
- Letter from County Veteran Service Officer or a VA representative
- Other: Explain: _____

BACKGROUND INFORMATION

A

Military Service Information

What name did you serve under in the military?

Full name _____

Last

First

Middle

What branch of service were you in? _____

What was your military service number? _____

What were your dates of active duty service?

From _____ until _____ Type of discharge _____

From _____ until _____ Type of discharge _____

Are you retired from the military? ☐ Yes ☐ No

Are you the surviving spouse of a Medal of Honor recipient or POW? ☐ Yes ☐ No

Veterans' Benefits Information

Have you ever applied for U.S. Department of Veterans Affairs (VA) benefits? ☐ Yes ☐ No

If yes, what is your VA claim number if known? Claim no.: _____

Do you have any service-connected disabilities? ☐ Yes ☐ No

If yes, what is the military disability percentage? _____

Do you receive non-service-connected pension benefits? ☐ Yes ☐ No

Do you or your spouse currently have a Cal-Vet loan? ☐ Yes ☐ No

(Note: On admission, Cal-Vet will be notified.) If yes: Contract no.: _____

Criminal Background Information

UPON ACCEPTANCE, YOU MAY BE FINGERPRINTED AND HAVE A CALIFORNIA DEPARTMENT OF JUSTICE CRIMINAL HISTORY SEARCH CONDUCTED

Have you ever had any criminal convictions? ☐ Yes ☐ No

If yes, provide the following: _____

Date

Type of conviction

County

State

Do you have any criminal charges pending? ☐ Yes ☐ No

If yes, describe: _____

BACKGROUND INFORMATION**A**Are you currently on probation or parole? ☐ Yes ☐ No

If yes: _____

Name of probation/parole officer

Address_____
Phone number_____
County_____
StateAre you required by law to register with local law enforcement? ☐ Yes ☐ NoAre you currently registered with your local law enforcement as required? ☐ Yes ☐ No

If yes: _____

County_____
State**Medical Information**

Have you received any medical, psychiatric, alcohol or drug treatment at any medical facility?

☐ Yes ☐ No

If yes, which one(s)?

1. _____
Name Address_____
City/State Zip Code Dates2. _____
Name Address_____
City/State Zip Code Dates3. _____
Name Address_____
City/State Zip Code Dates4. _____
Name Address_____
City/State Zip Code Dates5. _____
Name Address_____
City/State Zip Code Dates

BACKGROUND INFORMATION**A**Have you ever applied for admission or lived in any state Veterans Home? ☐ Yes ☐ No

If yes, where? _____

Name

Address

City/State

Zip Code

When? _____

From _____

until _____

Comments (add additional sheets if necessary):

Be aware that there are currently five Homes. If room is unavailable at your first choice that Home will pass your application package including medical information to the second, third or fourth choice and that Home should contact you for any additional or updated information.

_____ Barstow or check _____ I do not wish to apply for this location.

_____ Chula Vista or check _____ I do not wish to apply for this location.

_____ Lancaster or check _____ I do not wish to apply for this location.

_____ Ventura or check _____ I do not wish to apply for this location.

_____ Yountville or check _____ I do not wish to apply for this location.

The selected Home(s) may call you to assist in your application. Also, if you need help or have questions about your application please call:

Barstow Admissions Office 760-252-6315 or (Toll Free 800-746-0606)

Chula Vista Admissions Office 888-857-2146

Lancaster Admissions Office 661-974-8141

Ventura Admissions Office 805-659-7502

Yountville Admissions Office 800-400-8387

SIGNATURE_____
DATE

Veterans Home of California (VHC) Admission Application
**Authorization for Use and/or Disclosure of
Resident/Patient Health Information**

B

Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize _____
(NAME OF HOSPITAL OR PHYSICIAN YOU ARE REQUESTING RECORDS FROM)

(ADDRESS)

to disclose to _____ (CITY) _____ (STATE) _____ (ZIP)

(NAME OF VETERANS HOME YOU ARE APPLYING TO)

(ADDRESS)

(CITY) _____ (STATE) _____ (ZIP)

Records and information pertaining to

(NAME OF PATIENT) _____ (MEDICAL RECORD NUMBER) _____ (DATE OF BIRTH)

DURATION: This authorization shall become effective immediately and shall remain in effect until (Date) _____ or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party, My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

RE-DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Veterans Home of California (VHC) Admission Application
**Authorization for Use and/or Disclosure of
Resident/Patient Health Information**

B

SPECIFY RECORDS: Check the box and initial to specify type of information to be disclosed

☐ MEDICAL INFORMATION _____ (specify below)
INITIAL

☐ PSYCHIATRIC INFORMATION
[Cal. Wel. & Inst. Code §5328]

SIGNATURE

DATE

☐ DRUG/ALCOHOL INFORMATION
[42 C.F.R. §2.11 & 2.12]

SIGNATURE

DATE

☐ RESULTS OF AN HIV BLOOD TEST
(Health and Safety Code section 121020)

SIGNATURE

DATE

☐ OTHER INFORMATION _____ (specify below)
INITIAL

Specify the records to be disclosed: _____

The requester may use the health information authorized on this form for medical screening purposes only as outlined in Section G as part of their application for admission to a Veterans Home. A copy of this authorization will be given to the requestor.

Signature: _____ Date: _____ / _____ / _____
Month Day Year

If signed by other than resident/patient, indicate relationship: _____

[Ref. 45 C.F.R. §164.508; Cal.Civil Code §56.11]

Michigan Alcohol Screening Test - Geriatric

(MAST-G Screening Device – University of Michigan 1991)

C

Part of your application to the Veterans Home will be a review of your drinking habits. Alcohol is not allowed in resident's rooms, so we will ask you a few questions about your alcohol use.

Applicant name: _____ Date: _____

- | | | |
|---|-----|----|
| 1. After drinking have you ever noticed an increase in your heart beat or beating in your chest? | Yes | No |
| 2. When talking with others, do you ever underestimate how much you actually drink? | Yes | No |
| 3. Does alcohol make you sleepy so that you often fall asleep in your chair? | Yes | No |
| 4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry? | Yes | No |
| 5. Does having a few drinks help decrease your shakiness or tremors? | Yes | No |
| 6. Does alcohol sometimes make it hard for you to remember parts of the day or night? | Yes | No |
| 7. Do you have rules for yourself that you won't drink before a certain time of the day? | Yes | No |
| 8. Have you lost interest in hobbies or activities you used to enjoy? | Yes | No |
| 9. When you wake up in the morning, do you ever have trouble remembering part of the night before? | Yes | No |
| 10. Does having a drink help you sleep? | Yes | No |
| 11. Do you hide your alcohol bottles from family members? | Yes | No |
| 12. After a social gathering, have you ever felt embarrassed because you drank too much? | Yes | No |
| 13. Have you ever been concerned that drinking might be harmful to your health? | Yes | No |
| 14. Do you like to end an evening with a night cap? | Yes | No |
| 15. Did you find your drinking increased after someone close to you died? | Yes | No |
| 16. In general, would you prefer to have a few drinks at home rather than go out to social events? | Yes | No |
| 17. Are you drinking more now than in the past? | Yes | No |
| 18. Do you usually take a drink to relax or calm your nerves? | Yes | No |
| 19. Do you drink to take your mind off your problems? | Yes | No |
| 20. Have you ever increased your drinking after experiencing a loss in your life? | Yes | No |
| 21. Do you sometimes drive when you had too much to drink? | Yes | No |
| 22. Has a doctor or nurse ever said they were worried or concerned about your drinking? | Yes | No |

Michigan Alcohol Screening Test - Geriatric

(MAST-G Screening Device – University of Michigan 1991)

C

23. Have you ever made rules to manage your drinking? Yes No

24. When you feel lonely does having a drink help? Yes No

I answered these questions myself. Yes No

I had help answering these questions. Yes No

Applicant's Signature

Preparer's Signature

Additional comments you wish to make:

DRUG ABUSE SCREENING TEST (DAST)

(Reprinted with permission from Elsevier Science)



Part of your application to the Veterans Home will be a review of your use of non-prescription medications or drugs. Please answer all of the following questions as they apply to you any time over the past 5 years.

Applicant name: _____ Date: _____

- | | | |
|---|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Have you abused prescription drugs? | Yes | No |
| 3. Do you abuse more than one drug at a time? | Yes | No |
| 4. Can you get through the week without using drugs (other than those required for medical reasons)? | Yes | No |
| 5. Are you always able to stop using drugs when you want to? | Yes | No |
| 6. Do you abuse drugs on a continuous basis? | Yes | No |
| 7. Do you try to limit your drug use to certain situations? | Yes | No |
| 8. Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 9. Do you ever feel bad about your drug abuse ? | Yes | No |
| 10. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 11. Do your friends or relatives know or suspect you abuse drugs? | Yes | No |
| 12. Has drug abuse ever created problems between you and your spouse? | Yes | No |
| 13. Has any family member ever sought help for problems related to drug use? | Yes | No |
| 14. Have you ever lost friends because of your use of drugs? | Yes | No |
| 15. Have you ever neglected your family or missed work because of your use of drugs? | Yes | No |
| 16. Have you ever been in trouble at work because of drug abuse? | Yes | No |
| 17. Have you ever lost a job because of unusual behavior while under the influence of drugs? | Yes | No |
| 18. Have you gotten into fights when under the influence of drugs? | Yes | No |
| 19. Have you ever been arrested because of unusual behavior while under the influence of drugs? | Yes | No |
| 20. Have you ever been arrested for driving while under the influence of drugs? | Yes | No |
| 21. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 22. Have you been arrested for possession of dangerous drugs? | Yes | No |
| 23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? | Yes | No |
| 24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |

DRUG ABUSE SCREENING TEST (DAST)

(Reprinted with permission from Elsevier Science)

D

- | | | |
|---|-----|----|
| 25. Have you ever gone to anyone for help for a drug problem? | Yes | No |
| 26. Have you ever been in a hospital for medical problems related to drug use? | Yes | No |
| 27. Have you ever been involved in a treatment program specifically related to drug care? | Yes | No |
| 28. Have you been treated as an outpatient for problems related to drug use? | Yes | No |

I answered these questions myself	Yes	No
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I had help answering these questions	Yes	No
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Applicant's Signature

Preparer's Signature

Additional comments you wish to make:

DECLARATIONS



Name_____ Social security number_____

Read and initial each appropriate block, then sign your name at the end of this document.

1. Initial here_____ I am a bona fide resident of the state of California.

2. Initial here_____ I understand that if I am approved for admission to the Veterans Home of California, I will disclose all sources and the amount of my income, including increases and decreases, on an ongoing basis. The Department of Veterans Affairs of the state of California has the right to investigate my financial affairs and I consent to such an investigation.

3. Initial here_____ I understand that if I am admitted to the Veterans Home of California, admission will be on a conditional basis for the first 60 days of my residence. If I am discharged from the Veterans Home of California during the first 60 days of my residence, I understand that it will be my responsibility to arrange and pay for transportation from the Veterans Home of California to wherever I wish to go.

4. Initial here_____ If I am admitted to the Veterans Home of California, I agree to pay the prescribed amount of fees as set forth by California law.

5. Initial here_____ If I am admitted to the Veterans Home of California, reside at the required level of care, and I receive aid and attendance from the U. S. Department of Veterans Affairs and I have no dependents, I understand that I must pay the entire amount of my aid and attendance to the Veterans Home of California.

6. Initial here_____ I understand that as a condition of admission and continuing residency, I will, if eligible, apply for and maintain coverage in a federal, state, or private health insurance plan. As long as I am able and eligible, I will maintain this health coverage based on the direction of the Home's Finance Office.

DECLARATIONS



7. Initial here_____I have fully disclosed the details of the following:

- A. Medical history, including any and all medical treatments;
 - B. Psychiatric treatment or counseling;
 - C. History or current substance abuse problems;
 - D. Criminal convictions, probation, parole or mandatory county registration.
-

8. COLLECTION OF COST-OF-CARE IN EXCESS OF RESIDENT FEES

Military and Veterans Code Sections 1035 and 1035.05 provide that, upon the death of a resident of the Home, any money or personal property of that resident will first be paid to the Administrator of the Home to cover payment of funeral expenses or any obligation owed to the Home, *including* the cost of any care rendered by the Home in excess of the fees paid by the resident to the Home. The cost of care in excess of resident fees is often referred to as the un-reimbursed cost-of-care. If you are a resident of a California Veterans Home at the time of your death, the Home may disburse your money and/or personal property to the extent there are un-reimbursed costs of care at the time of your death.

CALCULATION OF THE UN-REIMBURSED COSTS OF CARE

The un-reimbursed cost-of-care is the difference between all resident account cost items and resident account cost offset items (reimbursements). Below is a brief description of how the un-reimbursed cost-of-care is calculated with examples of costs of care in excess of resident fees frequently incurred by residents and sources of reimbursements. (See also, California Code of Regulations, title 12, sections 506 and 507.)

A. COSTS OF CARE:

I. Room and Board Charges

The Room and Board Charges are the per-diem charges based on a resident's level of care and admission status for all services provided by the Home. The rate varies based on the level of care the resident receives and whether or not that resident is present at the Home. There could also be a difference in the cost of residence between the three California Veterans Homes. An example would be (current rates may vary) if you come into the Home at an independent level of care the cost would be \$95 and cost for the initial nursing level of care could be \$140 a day.

DECLARATIONS



The rate changes based on whether or not the person is physically present at the Home or not. This is because some of the costs associated with residence are fixed and are incurred regardless of whether the resident is physically present at the Home. When away from the Home you will be charged the lower daily "leave rate." An example would be (current rates may vary) if you are present and in independent level of care the cost would be about \$95/day but if you were away on vacation the cost would be \$47.50/day.

II. Outside Medical Expenditures

Outside medical expenditures include any amount paid on behalf of a resident to a health care provider outside of the Veterans Home. Typically this includes any medical and dental services ***for which the resident has no insurance and/or is not covered by Medicare or Medi-Cal.***

III. Other Medical Expenditures

This category of cost items includes co-payments or deductibles paid by the Home for treatment covered under the resident's medical insurance.

IV. Other Debits: Such as funeral expense or unpaid bills.

B. CALCULATION OF RESIDENT ACCOUNT COST OFFSET ITEMS (REIMBURSEMENTS)

I. Resident Fees Paid

This would include any fees paid by or on behalf of a resident that are authorized by Military and Veterans Code section 1012.3.

II. Aid and Attendance (A&A) Payments

For residents who receive an aid and attendance allowance from the United States Veterans Administration pursuant to 38 U.S.C. §§1502(b), 1521(d), and who have no dependent spouse, child, grandchild, or parent, the allowance is paid to the Veterans Home. All such payments remitted to the Home are used to reduce the un-reimbursed cost-of-care.

III. Veterans Administration Per Diem Payments

This item consists of payments from the United States Department of Veterans Affairs pursuant to 38 U.S.C. §1741 for the care of veterans at the Home. As the name implies, the payments are based on a daily rate. Like the cost-of-care above, the amount of these payments is based on the level of care provided to the resident.

DECLARATIONS



IV. Funds Received from Outside Sources

These would include any amounts received by the home for the benefit of the particular resident that do not fit into one of the above categories. Examples would include Medi-Cal, Medicare, supplemental insurance payments and any other voluntary payment, collection or net liquidation of assets received from external sources on behalf of a resident.

C. QUARTERLY STATEMENTS

Pursuant to Military and Veterans Code section 1035.6, each resident will receive a quarterly accounting statement of the total excess costs of care accrued to date. The statement is provided for informational purposes only, and is not a bill to be paid at the time of receipt. The **Exhibit A** of this section contains an **example** of the quarterly statements provided to residents of the Veterans Homes.

D. RESIDENTS WHO HAVE NO WILL AND NO HEIR AT THE TIME OF DEATH

If a resident of a Veterans Home dies without leaving a will or any heirs, any money or personal property in his or her estate will become the property of the Home and will be credited to the Morale, Welfare and Recreation Fund. (Military and Veterans Code section 1035.05)

E. ADVICE TO SEEK LEGAL COUNSEL

If you are concerned about the effect of Military and Veterans Code section 1035 and 1035.05 on your estate and would like to obtain guidance on how to protect your assets, you are advised to obtain counsel from a legal expert of your choosing at your own expense.

Initial here _____ *I have read the foregoing Notification of Costs of Care in Excess of the Resident Fees and understand that, should I die while a resident of the Home, the Veterans Home of California shall use all money and personal property belonging to me, to pay for funeral expenses and all costs of care rendered to me by the Home in excess of the fees I paid, and that this property and money will not be available to my heirs until such time as my funeral expenses and un-reimbursed costs of care have been paid. I also understand that if I die while a resident of the Home and do not have any heirs or a will at the time of my death, my estate will become the property of the Home and will be credited to the Morale, Welfare and Recreation Fund. I acknowledge that I have been advised of my right to seek legal counsel of my own choosing and at my own expense for purposes of determining the possible effect of the Military and Veterans Code section 1035 and 1035.05 on my estate and to obtain guidance on how to protect my assets.*

DECLARATIONS



The information provided in this application has been provided for the purpose of obtaining admission to the Veterans Home of California. I understand that if any information is found to be incorrect or incomplete that I may be denied admission to the Veterans Home of California.

I declare under the penalty of perjury of the laws of the state of California that the information provided herein is true and correct to the best of my knowledge and belief.

I authorize the California Department of Veterans Affairs (CDVA), its employees, officers, agents or designees to verify the information that has been provided in this application. I further authorize the U.S. Department of Veterans Affairs, the Department of Defense, the California Franchise Tax Board and any applicable law enforcement agency to release information about me to CDVA with the understanding that CDVA shall keep such information confidential.

Executed at County of: _____ State of: _____

Date _____ Signature _____

Witness signature _____

Print witness name _____

Witness address _____

DECLARATIONS**Exhibit A**
EXAMPLE ONLY**COSTS OF CARE IN EXCESS OF THE RESIDENT FEES**

Date: June 30, 2004
Name: John Q. Veteran
Address: Veterans Home of California—Chula Vista
Room B-26

Social Security No.: 123-45-6789
Period of Stay: April 1, 2003 through June 30, 2004

Resident Account Cost Items

Room and Board (SNF: 455 days @ \$175 per day)	\$79,625.00
Funeral Expenses	\$0.00
Other Debts (e.g. Fees Owed)	\$0.00
<u>Outside medical cost</u>	<u>\$1,200.00</u>
Total Cost	\$80,825.00

Resident Account Cost Offset Items

Insurance Payments	\$500.00
Balance of Trust Account (Inside Money)	\$0.00
Veterans Administration Per Diem Payments (\$50.55 per day for 455 days)	\$23,000.25
Resident Fee Payments (15 months at \$2,000 per month)	\$30,000.00
<u>Aid and Attendance Payments</u>	<u>\$15,000.00</u>
Total Cost Offsets	\$68,500.25
 Net Un-reimbursed Cost-of-care	 \$12,324.75

THIS IS NOT A BILL

Social Functioning Assessment

F

A FAMILY MEMBER, FRIEND, VETERANS SERVICE OFFICER OR SOCIAL WORKER WHO KNOWS YOU PERSONALLY MUST COMPLETE THIS FORM.

1. Applicant's name _____
Last First Middle
Social Security number _____ Date of birth _____

2. Applicant's next-of-kin _____ Relationship _____
Address _____
Daytime phone number _____ Evening phone number _____

3. Where is the applicant living?
☐ Home ☐ Hospital ☐ ICF (Assisted Living)
☐ Homeless ☐ Board and care ☐ SNF (Nursing Home)
☐ Other (specify) _____
Address _____
Who lives with him/her? _____

4. Check the activities of daily living applicant can do **WITHOUT** assistance: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Prepare meals | <input type="checkbox"/> Care for their property |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Read/Write | <input type="checkbox"/> Use community |
| <input type="checkbox"/> Walking or standing | <input type="checkbox"/> Follow verbal orders | resources |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Follow written orders | <input type="checkbox"/> Live alone |
| <input type="checkbox"/> Hygiene and grooming | <input type="checkbox"/> Carry on a | <input type="checkbox"/> Drive a motor vehicle |
| <input type="checkbox"/> Bathing/Showering | conversation | <input type="checkbox"/> Make/keep med. appt. |
| <input type="checkbox"/> Housecleaning | <input type="checkbox"/> Taking medications | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Handling money | |

5. Has the applicant completed an Advanced Health Care Directive? ☐ Yes ☐ No

Name of appointed Health Care Agent Address Phone number

Social Functioning Assessment

F

6. Does the applicant have a court -appointed: Conservator of Person? ☐ Yes ☐ No
Conservator of Estate? ☐ Yes ☐ No

Name of court-appointed Conservator Address Phone number

Please provide a copy of your court documents appointing you as conservator.

7. Does anyone handle his/her financial or personal affairs? ☐ Yes ☐ No

Name Address Phone number

8. Applicant's current hobbies, clubs, groups, veterans' organizations and other interests?

9. Check descriptions of applicant's behaviors: (check all that apply)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Socially withdrawn | <input type="checkbox"/> Sexually inappropriate | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Hostile | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Boisterous | <input type="checkbox"/> Outgoing |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Moody | |
| <input type="checkbox"/> Other (describe): _____ | | |

10. Describe typical daily activities

A. Morning _____
B. Afternoon _____
C. Evening _____
D. Night _____

11. Any additional information/comments

Social Functioning Assessment

F

I certify that the answers to the foregoing questions are true, correct and complete to the best of my personal knowledge and belief.

Executed at _____ County _____ State _____

Name (print) _____ Signature _____

Street address _____ City/State/Zip _____

Phone number _____ Length applicant known _____

Relationship _____ Date signed _____

Physician's Medical Certificate

G

This section to be completed by a physician and is designed to assess the resource needs for health care of the patient.

THIS CERTIFICATION IS VALID FOR **SIX MONTHS**. ALL INFORMATION MUST BE CURRENT AND COMPLETE TO AVOID DELAYS IN PROCESSING YOUR PATIENT'S APPLICATION.

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)**I. FACILITY INFORMATION** (To be completed by the licensee/designee)

1. NAME OF FACILITY		2. TELEPHONE ()
3. ADDRESS	CITY	ZIP CODE
4. LICENSEE'S NAME	5. TELEPHONE ()	6. FACILITY LICENSE NUMBER

II. RESIDENT/PATIENT INFORMATION (To be completed by the resident/resident's responsible person)

1. NAME	2. BIRTH DATE	3. AGE
---------	---------------	--------

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE
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IV. PATIENT'S DIAGNOSIS (To be completed by the physician)

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.

(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE
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6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: Negative Positive
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e. Results: mm _____ f. Action Taken (if positive): _____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

Active TB Disease

Latent TB Infection

No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a “conditional state” between normal aging and dementia.

Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

11. ALLERGIES:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? Yes No

c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? Yes No

c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION	a.	YES	NO	EXPLAIN
	Confused/Disoriented			
	Inappropriate Behavior			
	c. Aggressive Behavior			
	d. Wandering Behavior			
	e. Sundowning Behavior			
	f. Able to Follow Instructions			
	g. Depressed			
	h. Suicidal/Self-Abuse			
	i. Able to Communicate Needs			
	j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
	k. Able to Leave Facility Unassisted			
15. CAPACITY FOR SELF-CARE		YES	NO	EXPLAIN
	a. Able to Bathe Self			
	b. Able to Dress/Groom Self			
	c. Able to Feed Self			
	d. Able to Care for Own Toileting Needs			
	e. Able to Manage Own Cash Resources			
16. MEDICATION MANAGEMENT		YES	NO	EXPLAIN
	a. Able to Administer Own Prescription Medications			
	b. Able to Administer Own Injections			
	c. Able to Perform Own Glucose Testing			
	d. Able to Administer Own PRN Medications			
	e. Able to Administer Own Oxygen			
	f. Able to Store Own Medications			

17. AMBULATORY STATUS:

- a. This person is considered: Ambulatory Nonambulatory Bedridden

Nonambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

- b. If resident is nonambulatory, this status is based upon:

Physical Condition Mental Condition Both Physical and Mental Condition

- c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

Illness: _____

Recovery from Surgery: _____

Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

- d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____(number of days)
2. _____(estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain: _____

- e. Is resident receiving hospice care?

No Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS:

Good

Fair

Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE
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22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT

23. PHYSICIAN'S SIGNATURE

24. DATE